TESTIMONY BEFORE THE HOUSE COMMERCE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
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Good Morning, Mr. Chairman. I am Michael Mangano, Principal Deputy Inspector General, Department of Health and Human Services.

I am pleased to have this opportunity to summarize the results of our audits, inspections, and investigations on the Medicare home health program. Our office has done a considerable amount of work on this topic over the last several years. I hope this information will be useful to you in formulating legislation to deal with pervasive problems afflicting the home health program.

In summary, let me say that our work supports the need for prospective payment or other similar approaches for home health. Such systems are needed to prevent significant fraud, waste, and abuse that has arisen in this program and to control costs which are now almost uncontrollable. I wish to emphasize the immediacy of the need for action, and options to limit Medicare's exposure to losses while prospective payment systems are being developed.

Medicare Home Health Program. Medicare Part A pays for home health services for beneficiaries who are homebound, in need of care on an intermittent basis, and under the care of a physician who both establishes a plan of care and periodically reviews it. Beneficiaries receive numerous services including part-time or intermittent skilled nursing care; home health aide services; physical, speech and occupational therapy; medical equipment and supplies; and medical social services. The benefit is unlimited as long as the services are considered medically necessary.

Rapid Growth. All observers of Medicare's home health program are quick to describe its rapid growth. It is the fastest growing component of the Medicare program. FY 1996 expenditures are estimated to have been $16.9 billion, or five times the $3.5 billion spent in 1990. The number of beneficiaries increased from 2 to 3.7 million during this same period. Home health expenditures now account for 8.8 percent of total Medicare spending, compared to 3.5 percent in 1990. Utilization continues to rise from an average of 36 visits per Medicare beneficiary receiving home health benefits in 1990 to 72 visits in 1995, and an additional increase to 76 in 1996. The Congressional Budget Office has estimated that spending for home health services will reach $31 billion by 2002.

The reasons for the rapid growth of home health expenditures are well known--demographic trends, court cases which have liberalized coverage of the benefit, technological advances, such as

infusion therapies, which can now be provided at home, a growing and aging Medicare population, and a trend toward providing more care in the community instead of institutions. Growth can be attributed to the fundamental structure of the benefit as well as problems with the management of it.

Fraud and Abuse. It is unfortunately true that fraud and abuse also play a significant role in the high growth rates of home health.

A synopsis of some of the investigative cases completed by the Office of Inspector General over the past two years illustrates the vulnerability of the Medicare program and the type of home health fraud and abuse it is exposed to.

- The Chief Executive Officer and his wife and co-owner at a Georgia home health agency were convicted of conspiracy to defraud Medicare. They were accused of filing cost reports that included personal expenses, political contributions, ghost employees and lobbying expenses. They were also charged with mail fraud, paying kickbacks, making false statements, witness tampering, money laundering, and submitting false tax returns. The defendants were sentenced to 90 months and 32 months incarceration, respectively. These individuals and the company will pay $255 million fines, restitutions, and other penalties.

- The owner of a Louisiana home health agency was sentenced to 5 years probation and ordered to repay $119,000 for defrauding the Medicare program. The owner included in Medicare cost reports the expenses of a costume shop she owned and a magazine she produced monthly. Expenses charged included payroll, leases, telephone service, and advertising.

- The owner of a Texas Home health agency entered a settlement agreement to pay $493,000 in civil damages and penalties for submitting false Medicare claims. Investigation found that over a 9-month period, the agency billed Medicare for home health services for patients that were not homebound, and for services not rendered.

These are not isolated examples. We have now completed audits of eight home health agencies in Florida, Pennsylvania, and California. These audits revealed agency error rates--the percent of the home health visits paid for by Medicare but which did not meet Medicare guidelines--from 19 to 64 percent. We found visits that were not reasonable or necessary, patients who were not homebound, visits which were not documented or even provided to Medicare beneficiaries, and improper or missing physician authorizations. In a few cases we even found forged physician signatures. Preliminary data from Statewide audits underway in New York, Texas, Illinois, and California show similarly high error rates.

Unjustifiable Variation. We have also found extreme variation in payments to home health agencies. In FY 1993, lower cost home health agencies (those which provided less than the

national average of visits per episode) averaged 30 visits per episode, whereas the higher cost agencies (those with visits per episode above the national average) provided 85. One year later, the lower cost agencies provided 33 visits per episode, while the average for the higher cost agencies jumped to 102.

We tried to find out what could account for the variation in the number of visits.

Beneficiary characteristics and medical condition did not account for it. We specifically examined beneficiary age, race, gender, deaths while in care, qualifying conditions, and principal diagnostic codes. We found nothing here to suggest that beneficiaries in the high-cost groups were any sicker or in any greater need of medical services than those beneficiaries in the low and middle-cost groups.

We also found no differences in the quality of care provided by home health agencies, as measured by the number of deficiencies and complaints recorded by HCFA's Survey and Certification Branch and the home health agencies' accreditation status. Providers in the higher cost group had about the same number of deficiencies as did those in the lower groups.

We did find that private for-profit home health agencies tended to be the more costly. Additionally, we found that home health agencies in four southeastern States--Tennessee, Alabama, Mississippi, and Georgia--averaged twice as many visits per Medicare beneficiary as home health agencies in all other States. These four States averaged approximately 100 visits per episode compared to approximately 54 for all other States.

It appears to us that other than the geographic difference, the differences are due mostly to the discretion afforded home health agencies to influence the amount of care given to their clients.

Looking for Solutions. Our work has shown repeatedly that there is a need for greater control and protection from fraud and abuse. However, we must proceed cautiously to ensure that any measures to control the benefit do not harm those beneficiaries who truly need these services. Our focus must be on protecting the benefit as well as controlling expenditures and minimizing the potential for fraud and abuse.

The logical places to establish controls are: 1) HCFA's Regional Home Health Intermediaries, first at the point of certifying providers to participate in the Medicare program, and later when reviewing bills submitted for payment; 2) physicians authorizing the plan of care; 3) the beneficiaries receiving the care; and 4) the service providers.

Unfortunately, the volume of new providers entering the market and the volume of claims to be processed have made it extremely difficult for HCFA's intermediaries to scrutinize provider applications and bills as much as is needed to prevent fraud, waste, and abuse. HCFA is now developing new conditions of participation which may help prevent problem providers from entering the program; but the volume of claims will remain a problem for some time to come.

Physicians' involvement in home health care is inconsistent. Our studies have shown that they are typically involved in initial referrals of patients for home care, approving plans of care, and monitoring progress of complex patients. However, they are less involved in continuing monitoring of beneficiary eligibility, coordinating services, determining medical necessity of services, visiting patients at home, and participating in interdisciplinary conferences.

Likewise, Medicare beneficiaries have limited involvement in controlling home health services they receive. Many beneficiaries, while satisfied with the home health care they receive, do not understand what Medicare paid for. Furthermore, they have no financial liability or responsibility for the services. Therefore, beneficiaries have little incentive to control services.

Most home health service providers are dedicated to caring for their clients. They have not increased their visits just to maximize profits, but have focused on the needs to the beneficiaries under their care. Unfortunately, for unscrupulous providers, the current cost-based reimbursement systems does not provide incentives for providers to properly manage costs. In fact, it does just the opposite. Cost-based reimbursement provides incentives to increase revenues by providing more visits. Theoretically, home health agencies cannot themselves authorize home health visits. However, they can be very influential is obtaining certification from physicians.

To learn more about how costs can be controlled, we examined practices of private insurance companies, State Medicaid agencies, the Department of Veterans Affairs, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and numerous health maintenance organizations (HMOs). While their benefit structures were similar to Medicare's, they did try to control costs in ways that Medicare does not. For example, some place limits on the number of visits or caps on the dollar amount that can be paid. Many tried to target their programs more specifically to the individualized needs of their beneficiaries. They also undertook more intensive utilization control measures such as reviews of physician referral rates, post-pay edits, and utilization profiling combined with physician education.

We found that HMO's provide home health care for only one-fourth the cost of the Medicare fee-for-service program. The HMOs that responded to our survey spent an average of $882 per beneficiary in 1994 compared to Medicare's fee-for-service cost of $3,464. They do this by using case managers to review and approve patient care. These case managers work with physicians to plan care and write orders, review and approve both initial and continuing visits, review medical necessity, track and report outcomes and cost savings on a monthly basis, and participate in quality assurance activities such as clinical record reviews, team meetings, and case conferences. They carefully control both the number and kind of visits, constantly evaluating the care provided.

Administrative Remedies. HCFA has already begun to take administrative action to address problems which we have described here. As mentioned earlier, a new set of conditions of participation is under development. HCFA has also strengthened the role of its Survey and Certification teams by asking them to look for financial abuses during the surveys. HCFA has recently started issuing a Notification of Utilization (similar to the Explanation of Medical

Benefits used for other Medicare bills) to inform patients of the services billed on their behalf, and in other ways is reaching out to educate both beneficiaries and physicians about their roles in preventing abusive billing.

Additional steps can also be taken. Based on private sector practices and on our own analysis of weaknesses which we found, we have made several recommendations aimed at controlling Medicare expenditures and reducing the potential for fraud, waste and abuse. These include:

Focused HHA Reviews: Target the HHAs with average reimbursement higher than a standard established by HCFA for closer scrutiny by the Survey and Certification Branch as well as reviews by the Regional Home Health Intermediaries.

Regional Home Health Intermediary Resources and Flexibility: Ensure that Regional Home Health Intermediaries have adequate resources and tools to review applications for providers wishing to participate in the Medicare program and to detect and act on claims they suspect are fraudulent or abusive.

Case Management: Fund case management programs in the fiscal intermediaries. Case managers would be used to monitor and manage cases that reach a trigger point, or benefit threshold.

Beneficiary Certification: Require beneficiaries to certify their "homebound" status.

Stronger Physician Role: Require physicians to examine the patient before they order home health service. Require the patient to see the certifying physician at least once every 6 months.

Legislative Changes. However, we believe that management actions like these will not be sufficient. The problems are so commonplace that a restructuring of Medicare's payment system is called for. Options include:

Prospective Payment System: Establish a per episode prospective payment system. This may be the most effective long-term model for restructuring the benefit. We encourage HCFA to continue their work in testing such a system. We believe, however, that it is important that a new system not "grandfather" in utilization patterns of the higher-reimbursement agencies. It is worth noting that this was an important issue when a prospective payment system was being developed for hospitals.

Cap on Number of Visits Per Beneficiary: Limit the number of visits that Medicare will pay for any one beneficiary per year, or per episode. This would be similar to the approach Medicare takes for skilled nursing facilities.

Cost Limits Per Beneficiary: Develop a cost ceiling, limiting the amount payable in a given period for home health benefits on behalf of a beneficiary. The period to which the limit could apply might be lifetime, annual, or episodic. This is similar to a prospective payment system, except that it provides a cap rather than a fixed fee for services rendered. Also, the cap may or may not vary according to the diagnosis or treatment of the patient.

Visit Parameters Based on Condition: Set parameters on the number of visits a beneficiary may receive for a specified condition. When that parameter is reached, an additional set of conditions, documentation, or justification would be required to obtain reimbursement for additional visits.

Benefit Targeting: This is similar to the preceding option, but goes further by considering not only the number of visits authorized, but also the types of visits. Medicare might wish to channel patients with different needs (e.g., chronic vs. acute care patients) into different home health "programs", with different kinds of treatments, to create better, more appropriate care and greater program controls.

Limit on Average Number of Visits Per Beneficiary for Each Home Health Agency: Develop an average number of visits per beneficiary which HHAs may provide in a year. Beneficiaries who need a large number of visits would be offset by those who need very few visits. This budget would need to be flexible enough to allow for hardship cases, which warrant an unusually high number of visits, and/or adjusted for case mix.

Limit on Average Cost Per Beneficiary for Each Home Health Agency: This is the same as the preceding proposal, except that costs rather than visits would be used as the limiting factor.

Beneficiary Copayments: Require beneficiary copayments as a way to give them a stake in home health billings and to further ensure that unnecessary services are not provided. A copayment could begin upon admission or after a certain number of visits. This would create an incentive for patients and families to reduce over utilization. Medicare uses co-payments or other forms of co-insurance for most of its benefits.

Given the current rapid growth rate, it is important to take action quickly. If the goal is to establish a prospective payment system, and if that cannot be done immediately, we suggest that one or more of the approaches outlined above be used in the interim.

CONCLUSION

I appreciate the opportunity to appear before you today and share with you some of our work and recommendations related to Medicare home health services. I would be happy to respond to any questions you may have.